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DRAFT OMS GUIDELINES ON MEDICAL AND PSYCHOLOGICAL SUPPORT TO DETAINEE INTERROGATIONS

September 4, 2003

The following guidelines offer general references for medical officers supporting the detention of terrorists captured and turned over to the Central Intelligence Agency for interrogation and debriefing. There are three different contexts in which these guidelines may be applied: (1) during the period of initial interrogation, (2) during the more sustained period of debriefing at an interrogation site, and (3) the permanent detention of captured terrorists in long-term facilities.

INTERROGATION SUPPORT

Captured terrorists turned over to the C.I.A. for interrogation may be subjected to a wide range of legally sanctioned techniques, all of which are also used on U.S. military personnel in SERE training programs. These are designed to psychologically "dislocate" the detainee, maximize his feeling of vulnerability and helplessness, and reduce or eliminate his will to resist our efforts to obtain critical intelligence.

Sanctioned interrogation techniques must be specifically approved in advance by the Director, CTC in the case of each individual case. They include, in approximately ascending degree of intensity:

Standard measures (i.e., without physical or substantial psychological pressure)

Shaving

Stripping

Diapering (generally for periods not greater than 72 hours)

Hooding

Isolation

White noise or loud music (at a decibel level that will not damage hearing)

Continuous light or darkness

Uncomfortably cool environment

Restricted diet, including reduced caloric intake (sufficient to maintain general health)

Shackling in upright, sitting, or horizontal position

Water Dousing

Sleep deprivation (up to 72 hours)

Enhanced measures (with physical or psychological pressure beyond the above)

Attention grasp

Facial hold

Insult (facial) slap

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Abdominal slap
 Prolonged diapering
 Sleep deprivation (over 72 hours)
 Stress positions
 --on knees, body slanted forward or backward
 --leaning with forehead on wall
 Walling
 Cramped confinement (Confinement boxes)
 Waterboard

In all instances the general goal of these techniques is a psychological impact, and not some physical effect, with a specific goal of "dislocat[ing] his expectations regarding the treatment he believes he will receive...." The more physical techniques are delivered in a manner carefully limited to avoid serious physical harm. The slaps for example are designed "to induce shock, surprise, and/or humiliation" and "not to inflict physical pain that is severe or lasting." To this end they must be delivered in a specifically circumscribed manner, e.g., with fingers spread. Walling is only against a springboard designed to be loud and bouncy (and cushion the blow). All walling and most attention grasps are delivered only with the subject's head solidly supported with a towel to avoid extension-flexion injury.

OMS is responsible for assessing and monitoring the health of all Agency detainees subject to "enhanced" interrogation techniques, and for determining that the authorized administration of these techniques would not be expected to cause serious or permanent harm.¹ "DCI Guidelines" have been issued formalizing these responsibilities, and these should be read directly.

Whenever feasible, advance approval is required to use any measures beyond standard measures; technique-specific advanced approval is required for all "enhanced" measures and is conditional on on-site medical and psychological personnel² confirming from direct detainee examination that the enhanced technique(s) is not expected to produce "severe physical or mental pain or suffering." As a practical matter, the detainee's physical condition must be such that these interventions will not have lasting

¹ The standard used by the Justice Department for "mental" harm is "prolonged mental harm," i.e., "mental harm of some lasting duration, e.g., mental harm lasting months or years." "In the absence of prolonged mental harm, no severe mental pain or suffering would have been inflicted." Memorandum of August 1, 2002, p. 15.

² "Psychological personnel" can be either a clinical psychologist or a psychiatrist. Unless the waterboard is being used, the medical officer can be a physician or a PA; use of the waterboard requires the presence of a physician.

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effect, and his psychological state strong enough that no severe psychological harm will result.

The medical implications of the DCI guidelines are discussed below.

General intake evaluation

New detainees are to have a thorough initial medical assessment, with a complete, documented history and physical addressing in depth any chronic or previous medical problems. This should especially attend to cardio-vascular, pulmonary, neurological and musculo-skeletal findings. (See the section on shackling and waterboard for more specifics.) Vital signs and weight should be recorded, and blood work drawn ("tiger" top [serum separating] and lavender top tubes) for CBC, Hepatitis B and C, HIV and Chem panel (to include albumin and liver function tests).

Documented subsequent medical rechecks should be performed on a regular basis, the frequency being within the judgment of the medical representative and the Chief of Site. The recheck can be more focused on relevant factors. The content of the documentation should be similar to what would ordinarily be recorded in a medical chart. Although brief, the data should reflect what was checked and include ~~negative findings~~ (b)(3) NatSecAct. All assessments should be reported through approved (b)(3) NatSecAct communications channels applicable to the site in which the detainee is held, and subject to review/release by the Chief of the site. This should include an (b)(3) NatSecAct. A copy of the medical findings should also be included in an electronic file maintained locally on each detainee, which incorporates all medical evaluations on that individual. This file must be available to successive medical practitioners at site.

Medical treatment

It is important that adequate medical care be provided to detainees, even those undergoing enhanced interrogation. Those requiring chronic medications should receive them, acute medical problems should be treated, and adequate fluids and nutrition provided. These medical interventions, however, should not undermine the anxiety and dislocation that the various interrogation techniques are designed to foster. Medical assessments during periods of enhanced interrogation, while encompassing all that is medically necessary, should not appear overly attentive. Follow-up evaluations during this period may be performed in the guise of a guard or through remote video. All interventions, assessments and evaluations should be coordinated with the Chief of Site and interrogation team members to insure they are performed in such a way as to minimize undermining interrogation aims to obtain critical intelligence.

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Medications and nutritional supplements may be hidden in the basic food provided (e.g. as a liquid or thoroughly crushed tablet). If during the initial phase of interrogation detainees are deprived of all measurements of time (e.g., through continuous light and variable schedules), a time-rigid administration of medication (or nutrition) should be avoided. There generally is ample latitude to allow varying treatment intervals.

The basic diet during the period of enhanced interrogation need not be palatable, but should include adequate fluids and nutrition. Actual consumption should be monitored and recorded. Liquid Ensure (or equivalent) is a good way to assure that there is adequate nutrition. Brief periods during which food is withheld (24-48 hours) as an adjunct to interrogation are acceptable. Individuals refusing adequate liquids during this stage should have fluids administered at the earliest signs of dehydration. For reasons of staff safety, the rectal tube is an acceptable method of delivery. If there is any question about adequacy of fluid intake, urinary output also should be monitored and recorded.

Uncomfortably cool environments

Detainees can safely be placed in uncomfortably cool environments for varying lengths of time, ranging from hours to days. The length of time will depend on multiple factors, including age, health, extent of clothing, and freedom of movement. Individual tolerance and safety have to be assessed on a case by case basis, and continuously reevaluated over time. The following guidelines and reference points are intended to assist the medical staff in advising on acceptable lower ambient temperatures in certain operational settings. The comments assume the subject is a young, healthy, dry, lightly clothed individual sheltered from wind, i.e., that they are a typical detainee.

Core body temperature falls after more than 2 hours at an ambient temperature of 10°C/50°F. At this temperature increased metabolic rate cannot compensate for heat loss. The WHO recommended minimum indoor temperature is 18°C/64°F. The "thermoneutral zone" where minimal compensatory activity is required to maintain core temperature is 20°C/68°F to 30°C/86°F. Within the thermoneutral zone, 26°C/78°F is considered optimally comfortable for lightly clothed individuals and 30°C/86°F for naked individuals. Currently, D/CTC policy stipulates 24-26°C as the detention cell and interrogation room temperatures, permitting variations due to season. This has proven more achievable in some Sites than others.

If there is any possibility that ambient temperatures are below the thermoneutral range, they should be monitored and the actual temperatures documented. Occasionally, as part of the interrogation process they are housed in spaces with ambient temperatures of between 13°C/55°F and 16°C/60°F. Unless the detainee is clothed and standing, or sitting on a mat, this exposure should not be continued for longer than 2-3 hours.

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At ambient temperatures below 18°C/64°F, detainees should be monitored for the development of hypothermia. This risk is greatest in those who are naked or nearly so, who are in substantial direct contact with a surface that conducts heat away from the body (e.g., the floor), whose restraints severely limit muscle work, who have comparatively little muscle mass, who are fatigued and sleep deprived, and are age 45 or over.

Wet skin or clothing places a detainee at much greater risk for hypothermia, so if a partial or complete soaking is used in conjunction with the interrogation, or even for bathing, the detainee must be dry before being placed in a space with an ambient temperature below 26°C/78°F.

Signs of mild hypothermia (body temp 90-98°F) include shivering, lack of coordination (fumbling hands, stumbling), slurred speech, memory loss, and pale and cold skin. Detainees exhibiting any of these signs should be allowed some combination of increased clothing, floor mat, more freedom of movement, and increased ambient temperature.

Moderate hypothermia (body temperature of 86-90°F) is present when shivering stops, there is an inability to walk or stand, and/or the subject is confused/irrational. An aggressive medical intervention is warranted in these cases.

White noise or loud music

As a practical guide, there is no permanent hearing risk for continuous, 24-hours-a-day exposures to sound at 82 dB or lower; at 84 dB for up to 18 hours a day; 90 dB for up to 8 hours, 95 dB for 4 hours, and 100 dB for 2 hours. If necessary, instruments can be provided to measure these ambient sound levels. In general, sound in the dB 80-99 range is experienced as loud; above 100 dB as uncomfortably loud. Common reference points include garbage disposer (80 dB), cockpit of propeller aircraft (88 dB), shouted conversation (90 dB), motorcycles at 25 feet (90 dB), inside of subway car at 35 mph (95 dB), power mower (96 dB), chain saw (110 dB), and live rock band (114 dB). For purposes of interrogation, D/CTC has set a policy that no white noise and no loud noise used in the interrogation process should exceed 79 DB.

Shackling

Shackling in non-stressful positions requires only monitoring for the development of pressure sores with appropriate treatment and adjustment of the shackles as required. Should shackle-related lesions develop, early intervention is important to avoid the

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development of an interrogation-limiting cellulitis. Cleaning the lesion, and a slight loosening of the shackles may be all that is required.

If the detainee is to be shackled standing with hands at or above the head (as part of a sleep deprivation protocol), the medical assessment should include a pre-check for anatomic factors that might influence how long the arms could be elevated. This would include shoulder range of motion, pulses in neutral and elevated positions, a check for bruits, and assessment of the basic sensorimotor status of the upper extremities.

Assuming no medical contraindications are found, extended periods (up to 72 hours) in a standing position can be approved if the hands are no higher than head level and weight is borne fully by the lower extremities. Detainees who have one foot or leg casted or who lost part of a lower extremity to amputation should be monitored carefully for the development of excessive edema in the weight-supporting leg. If edema approaches knee level, these individuals should be shifted to a foot-elevated, seated or reclining sleep-deprivation position. In the presence of a suspected lower limb cellulitis, the detainee should be shifted to a seated leg-elevated position, and antibiotics begun. Absent other contraindications, sleep deprivation can be continued in both these circumstances..

NOTE: An occasional detainee placed in a standing stress position has developed lower limb tenderness and erythema, in addition to an ascending edema, which initially have not been easily distinguished from a progressive cellulitis or venous thrombosis. These typically have been associated with pre-existing abrasions or ulcerations from shackling at the time of initial rendition. In order to best inform future medical judgments and recommendations, the presence of these lesions should be accurately described before the standing stress position is employed. In all cases approximately daily observations should be recorded which document the length of time the detainee has been in the stress position, and level of any developing edema or erythema.

More stressful shackled positions may also be approved for shorter intervals, e.g. during an interrogation session or between sessions. The arms can be elevated above the head (elbows not locked) for roughly two hours without great concern. Reasonable judgment should be used as to the angle of elevation of the arms.

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Periods in this arms-elevated shackle position lasting between two and four hours would merit caution, and subject should be monitored for excessive distress. The detainee should never be required to bear weight on the upper extremities, and the utilization of this technique should not exceed approximately 4 hours in a 24 hour period. If through fatigue or otherwise the detainee becomes truly incapable of supporting himself on his feet (e.g., after 36, 48 hours, etc.), and the detainee's weight is shifted to the shackles, the use of overhead shackles should be discontinued.

Sleep deprivation

Sleep deprivation (with or without associated stress positions) is among the most effective adjuncts to interrogation, and is the only technique with a demonstrably cumulative effect—the longer the deprivation (to a point), the more effective the impact. The standard approval for sleep deprivation, per se (without regard to shackling position) is 72 hours. Extension of sleep deprivation beyond 72 continuous hours is considered an enhanced measure, which requires D/CTC prior approval. The amount of sleep required between deprivation periods depends on the intended purpose of the sleep deprivation. If it is intended to be one element in the process of demonstrating helplessness in an unpleasant environment, a short nap of two or so hours would be sufficient. Perceptual distortion effects are not uncommon after 96 hours of sleep deprivation, but frank psychosis is very rare. Cognitive effects, of course, are common. If it is desired that the subject be reasonably attentive, and clear-thinking during the interrogation, at least a 6 hour recovery should be allowed. Current D/CTC policy requires 4 hours sleep once the 72 hour limit has been met during standard interrogation measures.

NOTE: Examinations performed during periods of sleep deprivation should include the current number of hours without sleep; and, if only a brief rest preceded this period, the specifics of the previous deprivation also should be recorded.

Cramped confinement (Confinement boxes)

Detainees can be placed in awkward boxes, specifically constructed for this purpose. These can be rectangular and just over the detainee's height, not much wider than his body, and comparatively shallow, or they can be small cubes allowing little more than a cross-legged sitting position. These have not proved particularly effective, as they may become a safehaven offering a respite from interrogation. Assuming no significant medical conditions (e.g., cardiovascular, musculoskeletal) are present, confinement in the small box is allowable up to 2 hours. Confinement in the large box is limited to 8 consecutive hours, up to a total of 18 hours a day.

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Waterboard

This is by far the most traumatic of the enhanced interrogation techniques. The historical context here was limited knowledge of the use of the waterboard in SERE training (several hundred trainees experience it every year or two). In the SERE model the subject is immobilized on his back, and his forehead and eyes covered with a cloth. A stream of water is directed at the upper lip. Resistant subjects then have the cloth lowered to cover the nose and mouth, as the water continues to be applied, fully saturating the cloth, and precluding the passage of air. Relatively little water enters the mouth. The occlusion (which may be partial) lasts no more than 20 seconds. On removal of the cloth, the subject is immediately able to breathe, but continues to have water directed at the upper lip to prolong the effect. This process can continue for several minutes, and involve up to 15 canteen cups of water. Ostensibly the primary desired effect derives from the sense of suffocation resulting from the wet cloth temporarily occluding the nose and mouth, and psychological impact of the continued application of water after the cloth is removed. SERE trainees usually have only a single exposure to this technique, and never more than two; SERE trainers consider it their most effective technique, and deem it virtually irresistible in the training setting.

Our very limited experience with the waterboard is different. The subjects were positioned on the back but in a slightly head down (Trendelenburg) position (to protect somewhat against aspiration). A good air seal seemingly was not easily achieved by the wet cloth, and the occlusion was further compromised by the subject attempting to drink the applied water. The result was that copious amounts of water sometimes were used-- up to several liters of water (bottled if local water is unsafe, and with 1 tsp salt/liter if significant swallowing takes place). The resulting occlusion was primarily from water filling the nasopharynx, breathholding, and much less frequently the oropharynx being filled--rather than the "sealing" effect of the saturated cloth. D/CTC policy set an occlusion limit of 40 seconds, though this was very rarely reached. Additionally, the procedure was repeated sequentially several times, for several sessions a day, and this process extended with varying degrees of frequency/intensity for over a week.

While SERE trainers believe that trainees are unable to maintain psychological resistance to the waterboard, our experience was otherwise. Subjects unquestionably can withstand a large number of applications, with no seeming cumulative impact beyond their strong aversion to the experience. Whether the waterboard offers a more effective alternative to sleep deprivation and/or stress positions, or is an effective supplement to these techniques is not yet known.

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The SERE training program has applied the waterboard technique (single exposure) to trainees for years, and reportedly there have been thousands of applications without significant or lasting medical complications. The procedure nonetheless carries some risks, particularly when repeated a large number of times or when applied to an individual less fit than a typical SERE trainee. Several medical dimensions need to be monitored to ensure the safety of the subject.

Before employing this technique there needs to be reasonable assurance that the subject does not have serious heart or lung disease, particularly any obstructive airway disease or respiratory compromise from morbid obesity. He also must have stable anterior dentition, no recent facial or jaw injuries, and an intact gag reflex. Since vomiting may be associated with these sessions, diet should be liquid during the phase of interrogation when use of the waterboard is likely, and the subject should be NPO (other than water) for at least 4 hours before any session. The most obvious serious complication would be a respiratory arrest associated with laryngospasm, so the medical team must be prepared to respond immediately to this crisis; preferably the physician will be in the treatment room. Warning signs of this or other impending respiratory complications include hoarseness, persisting cough, wheezing, stridor, or difficulty clearing the airway. If these develop, use of the waterboard should be discontinued for at least 24 hours. If they recur with later applications of the waterboard, its use should be stopped. Mock applications need not be limited. In all cases in which there has been a suggestion of aspiration, the subject should be observed for signs of a subsequently developing pneumonia.

In our limited experience, extensive sustained use of the waterboard can introduce new risks. Most seriously, for reasons of physical fatigue or psychological resignation, the subject may simply give up, allowing excessive filling of the airways and loss of consciousness. An unresponsive subject should be righted immediately, and the interrogator should deliver a sub-xyphoid thrust to expel the water. If this fails to restore normal breathing, aggressive medical intervention is required. Any subject who has reached this degree of compromise is not considered an appropriate candidate for the waterboard, and the physician on the scene can not approve further use of the waterboard without specific C/OMS consultation and approval.

A rigid guide to medically approved use of the waterboard in essentially healthy individuals is not possible, as safety will depend on how the water is applied and the specific response each time it is used. The following general guidelines are based on very limited knowledge, drawn from very few subjects whose experience and response was quite varied. These represent only the medical guidelines; legal guidelines also are operative and may be more restrictive.

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A series (within a "session") of several relatively rapid waterboard applications is medically acceptable in all healthy subjects, so long as there is no indication of some emerging vulnerability (such as hoarseness, wheezing, persisting cough or difficulty clearing the airways). Several such sessions per 24 hours have been employed without apparent medical complication. The exact number of sessions cannot be prescribed, and will depend on the response to each. If more than 3 sessions of 5 or more applications are envisioned within a 24 hours period, a careful medical reassessment must be made before each later session.

By days 3-5 of an aggressive program, cumulative effects become a potential concern. Without any hard data to quantify either this risk or the advantages of this technique, we believe that beyond this point continued intense waterboard applications may not be medically appropriate. Continued aggressive use of the waterboard beyond this point should be reviewed by the HVT team in consultation with Headquarters prior to any further aggressive use. (Absent medical contraindications, sporadic use probably carries little risk.) Beyond the increased medical concern (for both acute and long term effects, including PTSD), there possibly would be desensitization to the technique. Sleep deprivation is a medically less risky option, and sleep deprivation (and stress positions) also can be used to prolong the period of moderate use of the waterboard, by reducing the intensity of its early use through the interposition of these other techniques.

NOTE: In order to best inform future medical judgments and recommendations, it is important that every application of the waterboard be thoroughly documented: how long each application (and the entire procedure) lasted, how much water was used in the process (realizing that much splashes off), how exactly the water was applied, if a seal was achieved, if the naso- or oropharynx was filled, what sort of volume was expelled, how long was the break between applications, and how the subject looked between each treatment.

POST-INTERROGATION DETENTION
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OMS' responsibility for the medical and psychological well-being of detainees does not end when detainees emerge from the interrogation phase. Documented periodic medical and psychological re-evaluations are necessary during the debriefing phase which follows interrogation, as well as during subsequent periods of custodial detention. Absent any specific complaint, these can be at approximately monthly intervals. Acute problems must be addressed at the time of presentation. As during the interrogation phase, all assessments, examinations, and evaluations should be reported through approved (b)(3) NatSecAct communications channels applicable to the site in which the detainee is held, and subject to review/release by the Chief of that site.

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Detainee weights should be recorded on at least a monthly basis, and assessed for indications of inadequate nutrition. As a rule of thumb, "ideal" weight for height should be about 106 pounds for an individual 5 feet tall, and six pounds heavier for each additional inch of height. Terrorists incarcerated in the Federal prison system whose weights fall below this level are given nutritional supplements. Those falling to 90% of these levels who are unwilling to take nutrition orally (through hunger strikes) have forced feedings through a naso-gastric tube. While to date this has not been an issue with detainees, should significant weight loss develop it must be carefully assessed. It is possible that a detainee will simply be of slight build, but true weight loss in an already slight individual—especially in association with deliberately reduced intake—may require some intervention.

Additionally, if there are sustained periods without exposure to sunlight, the diet will need to be further supplemented with calcium and vitamin D. Simply increasing the use of multi-vitamins will give too much of one substance but not enough of another. The OMS recommendation for this situation is two 500 mg tablets of plain calcium a day (such as two Os-Cal 500 mg tabs) with one capsule of the prescription Rocaltrol; or alternatively two Centrum Silver tablets (slightly less than the recommendation for vitamin D) with an additional 500 mg of a plain calcium table.

As the period of interrogation or intense debriefing passes, detainees may be left alone for increasing periods of time before being transferred elsewhere. Personal hygiene issues likely will emerge during this time, with the possible development of significant medical problems. It is particularly important that cells be kept clean during this period and that there be some provision for regular bathing, and dental hygiene, and that detainees be monitored to insure they are involved in self-care.

Psychological problems are more likely to emerge in those no longer in active debriefings, especially those in prolonged, total isolation. The loss of involvement with the debriefing staff should be replaced with other forms of interaction—through daily encounters with more than one custodial staff member, and the provision of reading materials (preferably in Arabic) and other forms of mental stimulation.

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